Vyvgart Hytrulo Infusion Order

Fax 888 511-7654 *Phone 888 864-7341*

Patient Name: ______________________________ **DOB:** ______________________
Patient Phone: ______________________________ **SEX:** **M** **F**

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

G70.00 Myasthenia Gravis without Exacerbations
G70.01 Myasthenia Gravis with Acute Exacerbation
G61.81 Chronic Inflammatory Demyelinating Polyneuritis
Other ____________________

Patients weight: _________
Lab Date: ____________________
Allergies: ____________________

ICD-10 ____________________

ALSO INCLUDE...
Clinical/ Progress Notes
Demographics Sheet
Current Medications
Labs

VYVGART ORDER

Vyvgart Hytrulo Dose: 1,008mg/ 11,200 units SubQ injection once weekly x4 doses

Frequency:

One cycle only
Repeat cycles every 28 days from the last dose for 6 total cycles for one full year
Repeat cycle every 28 days from last dose for __________ total cycles

Date of last Vyvgart Hytrulo Infusion: ________________

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: ____________________________ **Phone:** ____________________

Practice Address: ____

Office Contact: ________________________________ **Fax:** ____________________

NPI/ TIN: ______________________

Referring Physician's Signature_________________________________ **Date:** __________